Empathy in the Physician-Patient Relationship:

How Physicians Define, Develop, and Demonstrate Emotional Work in Clinical Practice

Amol Utrankar

Dr. Elaine Ecklund

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ABSTRACT

In recent years, much research has been focused on the role of empathy in the patient-physician relationship. Empathy has been shown to improve patient communication, trust, and clinical outcomes. Driven by this evidence, the physician-patient interaction has shifted in recent decades from a relationship that once discouraged empathy to one that now requires it as a fundamental element of the physician scope of practice. The majority of this research examines correlates of empathetic behavior, longitudinal changes in patient-centeredness scores, or behavioral coding of physician-patient relationships, leaving knowledge gaps in questions of meaning or process surrounding clinical empathy. This study attempts to link the quantitative aspects of medical research on empathy with the sociological concept of emotion labor. Semi-structured narrative interviews will be conducted with emergency medicine physicians and residents at two Level I trauma centers at academic medical centers. As an outcome, this study aspires to understand how physicians conceptualize empathy, consider its role within their broader scope of responsibilities, and experience changes in empathy over time. These findings will provide an explanatory theoretical framework of empathy in the medical setting to strengthen future evaluations and interventions.

INTRODUCTION

The social interaction between physician and patient has historically been recognized as a critical aspect of effective medical care; most famously, Francis Peabody codified the role of humanity in medicine with the statement, "One of the essential qualities of the clinician is interest in humanity, for the secret of the care *of* the patient is in caring *for* the patient" (Peabody 1927:882). In recent years, medical researchers have studied the relevance of the doctor-patient relationship as a clinical intervention in itself. Studies associate empathy with improved physician-patient communication, trust, treatment adherence, and clinical outcomes (Gerteis et al. 1993; Stewart 1995; Di Blasi et al. 2001; Halpern 2001). In light of such extensive corroborative evidence, empathy has shifted from a mark of distinction to something that is part of the standard operating procedures of clinical care.

Though such developments offer significant benefits to patients, this study considers the physician-patient relationship from an alternate perspective and examines how the emphasis on empathy as a clinical intervention has affected the training, practice, and emotional wellness of physicians themselves. For the physician community, the topic of emotional engagement in medicine is a major concern because of the significant effect that such interactions have on clinicians. There are numerous studies describing the prevalence of empathy decline, depersonalization, emotional exhaustion, and other psychological stressors among physicians (Visser et al. 2003; Shanafelt et al. 2012). The causes of these factors remain incompletely understood, but studies have linked them to the demands for time and emotional investment that physicians face. Academic clinicians currently seek to understand how the physician-patient relationship influences psychosocial stress in clinicians. Additionally, studies have shown that empathy and patient-centeredness decrease over the course of medical education and practice,

and the rationale and determinants behind this transition remain unclear (Hojat et al. 2009). Most critically, the existing medical literature has relied on constructs of physician surveys and behavioral coding to measure and evaluate empathy, without necessarily providing due consideration for how accurately these quantitative analyses reflect the broader theory of how physicians conceptualize, develop, and manage emotion (Pedersen 2009).

The doctor-patient relationship is a deeply personal interaction between the care provider and recipient, but it still has sociological relevance as a study of clinicians as a social group and as a study of emerging social trends within the medical community. Empathy in medicine is a nested topic within the broader discipline of sociology of labor. More specifically, clinical empathy draws upon elements of emotion labor, which examines how emotions are handled during interactions in a professional context (Hochschild 1983). This study applies a sociological framework to examine the phenomenon of patient-physician emotional engagement, attempting to address the questions that existing literature has left undetermined and to link the empirical studies in the medical literature to the theoretical discussions in the sociological literature. How do physicians define empathy? How do physicians consider empathy in the scope of their professional responsibilities, and how do they manage any emotional and cognitive challenges that arise when incorporating emotion into patient care? How does empathy develop or erode in physicians over time, from both environmental factors in the medical environment or from the process of professional socialization during clinical training? These are all relevant considerations that are not addressed in existing literature, yet have significant potential to inform both medical and sociological studies on clinical empathy.

To date, the majority of literature on empathy in medicine is quantitative, and studies with qualitative methods or less structured orientations are scarce (Pedersen 2009). This study

will examine the conceptualization, development, and management of physician empathy from the previously unexplored perspective of the semi-structured narrative interview format. Like many of the surveys, cognitive indices, and behavioral coding methods that currently shape existing literature, the semi-structured interview is a self-reported measure that relies on the (often retrospective) perceptions of the subject. However, the interview offers an opportunity to examine topics such as longitudinal development of social processes and open-ended conceptualizations of phenomena that are rarely possible with more structured methods of data collection. In light of the sizable conceptual assumptions and concerns of validity on which the present literature is built, the proposed study will yield novel theoretical insight into how physicians view and utilize emotions in their professional scope.

LITERATURE REVIEW

Over the past half-century, there has been a paradigm shift in the 'best practices' of bedside conduct from a detached, paternalistic relationship towards a more empathic, patient-centered model of care. The earlier literature on empathy in medicine, by consensus, largely considers emotional interaction between physicians and patients to be a taboo topic. Many qualitative perspectives on physician training from the 1960s and 1970s characterize affective disengagement as the expected standard of care, with varying explanatory models for why physicians exhibit—or should exhibit—detached behavior. Many of these theories have strong roots in medical education and clinical training. In Haas and Shaffir's (1997) model, physician trainees are burdened by patients' expectations of clinical competence and authority; consequently, neophyte physicians distance themselves from patients to convey the impression that they are competent and professional. Another study suggests that the informal curriculum of clinical training instructs physicians to adopt an objectified, depersonalized view of patients to

avoid emotional interference with the objective processes of clinical decision-making (Coombs and Powers 1975). Becker et al. (1961) corroborated this viewpoint, observing the consensus among physicians that emotions and personal concerns ought not to hinder the physician's professional duty to treat the patient's disease. Other theories attribute emotional detachment to the environmental stressors of medicine. Beale and Kriesberg (1959) propose that medical students develop a sense of cynicism in response to the rigors and stresses of the morbid hospital environment, while a review of literature by Smith and Kleinman (1989) finds that physicians use detachment as a tool to deal with death, medical errors, and uncertainty of clinical decision-making (also see Sudnow 1967; Bosk 1979; Fox 1980). Medical practice has since adapted to more significantly embrace empathy in the physician-patient relationship. Nonetheless, these earlier studies merit mention because it is possible that they may still be informally prevalent in medical education or may have a residual influence on the culture of medicine.

Today, at least in medical literature, educational curricula, and codified standards, empathy has become an integral element of the physician's standard of care. The study of how physicians understand empathy, along with the investigation of experiences and circumstances that shape emotional socialization within medicine, is situated within Hochschild's (1983) study of emotion work. Hochschild's work is based on the understanding that emotions are governed by rules of social rules and norms. These feeling rules shape how individuals should present themselves in certain social circumstances; consequently, Hochschild observes that subjects often adjust their emotions to make their own feelings concordant with what they perceive to be the social expectations for emotions in a given situation. When an individual's emotions are not concordant with social norms—a case that Hochschild terms "emotive dissonance"—he adjusts his feelings in one of two ways: surface acting and deep acting. Surface acting is a construction

of an external emotional façade that contrasts with the subject's internal emotions, while deep acting is an adjustment of internal perceptions and sentiments to align the internal emotional state with social norms. More directly, surface acting is a superficial manifestation, while deep acting is a genuine emotional and cognitive conversion.

Within emotion work, emotion labor is a particular sub-discipline that evaluates the management of emotional relationships between employees, employers, and customers. Just as emotion work is the study of situational norms of emotionality, emotion labor focuses on the circumstances of professionals that rely heavily on interpersonal communication on a daily basis, such as flight attendants, lawyers, waiters, and physicians. Multiple studies in business and organizational behavior highlight how positive affect and quality service are important for strong customer satisfaction, consumer retention, and business prosperity (Rust and Zahorik 1993; Zeithaml et al. 1996; Hu et al. 2009). Hochschild (1983:7) understands this obligation to be the basis of emotion labor, which "requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others." Thus, emotion labor is a special case of emotion work where emotional engagement is more than socially appropriate and morally laudable. In emotion labor, it is obligatory and entirely non-negotiable, according to professional standards, that the emotional laborer maintains an outward demeanor that is responsive to the needs of the people he or she interacts with.

When emotional engagement shifts from a social expectation to a professional compulsion, the result is the commodification of human emotion (Lively 2007). Sociologists of emotion and labor contend that when workers exchange their emotions for wages, they develop a habit of emotive dissonance that can cause them to become alienated from the products of their labor and isolated from their genuine, autonomous self-identity (Erickson and Wharton 1997;

Abraham 1998; Brotheridge and Grandey 1998; Ashforth and Tomiuk 2000; Grandey, 2003; Lively 2007). Van Maanen's profile of service employees at Disneyland, stylized the "Happiest Place on Earth," depicts the challenges of sustained emotion labor (Van Maanen 1992:58). At Disneyland, employees are given strict instructions to maintain authenticity of acting roles and adhere to a positive demeanor, under pressure of scrutinized observation from fellow employees, hordes of guests, and plainclothes supervisors. Under the burdens of emotion labor, employees develop a sense of emotional exhaustion that Van Maanen describes as "automatic pilot," "going robot," or "lapsing into a dream" (Van Maanen 1992:74). Similarly, Leidner's study of service workers in the fast food industry describes the emotional exhaustion and cynicism resulting from employees' frustration with the pressures of meeting customers' expectations and presenting an artificially positive display of surface acting (Leidner 1999).

Here, it is important to distinguish that physicians and patients are not bound by an employee-customer service contract like amusement park ride operators or fast food employees, nor do physicians generally view their patients as customers (Hartzband and Groopman 2011). Though medical discourse surrounding the doctor-patient paradigm is shifting from a paternalistic model towards a more egalitarian, collaborative relationship, the power dynamic still favors the healthcare provider, which is unlike the responsiveness that other service professionals have towards the people they work with. Consequently, the extent to which the language and power dynamics of standard emotion labor relationships apply to medicine has not been fully explored, and remains debatable.

Still, given the empirical evidence on patient-provider relationships and emotional management in medicine, there are some reasons to consider the emotional labor model plausibly relevant to describe the relationships and practices of healthcare providers. For one,

communication and emotional engagement with patients are critical emphases in the training and practice of medicine (Simpson et al. 1991; Ong et al. 1995; Makoul and Schofield 1999; Halpern 2001). The expectation on physicians to demonstrate affective behavior towards patients has become increasingly essential as a growing body of research has strengthened the link between physician empathy, patient satisfaction, and positive treatment outcomes for patients. This body of research includes studies on physician affect and empathy as determinants of patient emotional wellbeing (Bertakis et al. 1991; Zacharie et al. 2003; Kim et al 2004), as determinants of increased patient commitment to healthy practices (Roter et al. 1998; Weng 2008; Haskard Zolnierek and DiMatteo 2009), and as determinants of objective metrics of patient health outcomes (Beck et al. 2002; Franks et al. 2006; Hojat et al. 2011). The mechanisms of the relationship between patient-physician emotional engagement, satisfaction, and clinical outcomes remain unclear. One proposed explanation suggests that the physicians that are empathetic are also those who are most adept at producing positive clinical outcomes. An alternative viewpoint proposes that the action of engaging and satisfying the patient opens lines of trust, thorough communication, and adherence to treatment regimens that collectively yield strong clinical results. The process of empathy's clinical benefits aside, the literature demonstrates a strong benefit to the emotional labor in the physician-patient relationship, creating an expectation upon physicians to maintain a certain external disposition.

Having considered the theoretical foundations of emotion labor and emotion management in medicine, we arrive at the conclusion that much is still uncertain about how physicians understand and manage empathy in their professional lives. What is known is that medicine is becoming a more empathic, patient-centered profession—at least in policy if not in practice—and that the standards of medical education and professional conduct have been adjusted to meet

this change (Laine and Davidoff 1996). It is known that this empathy improves the physician-patient relationship and improves patient outcomes, as previously described. Furthermore, it is known that, despite the emphasis and evidence in favor of empathic behavior, physicians experience declines in empathy and patient-centeredness over the course of their medical training (Hojat et al. 2009). Researchers also recognize that physicians experience high rates of adverse psychosocial outcomes like depersonalization, burnout, and exhaustion over time, and Hochschild's work on emotion labor suggests that the emphasis on empathy and pressures toward surface acting may be partially responsible for such negative mental stressors (Hochschild 2003; Visser et al. 2003; Shanafelt et al. 2012). While these foundations are understood to shape the existing knowledge of empathy in clinical practice, what is missing is the precision of 'how' and 'what.' The current literature has not adequately explored the processes that shape empathy development over time, or the ways that physicians interpret the role of empathy within their patient care responsibilities. At the most basal level, the current literature has not arrived at a conclusive functional definition of empathy, which detracts from the quality of the available literature.

To date, there has largely been a disconnect between studies of empathy and emotional burnout in the medical literature, and the broader sociological theory of emotion labor that encompasses physician burnout. As a result, those with a scientific-oriented clinical training have framed the existing work on emotion labor in medicine in terms of scientific, heavily quantitative language: correlates of burnout, statistically significant determinants of burnout, and longitudinal trends in indices of burnout over time. Such work is meaningful, and its findings have lent much value to the refinement of medical training to identify and prevent emotional exhaustion. Yet what is missing in this literature is a rigorous evaluation of process and meaning: how empathy is

conceptualized among physicians, how emotional labor is managed over time, and how the challenges of meeting expectations of emotional engagement are balanced with the internal demands for objectivity or emotional self-protection. The disconnect between theory and empirical analysis has been gradually cemented by an absence of concrete definitions for empathy or burnout—causing distinct terms like empathy, burnout, exhaustion, emotional labor, depersonalization, or dissonance to be discussed synonymously and erratically. When constructing a study on empathy, the semantics are significant; empathy can be defined as either a cognitive process, in which a subject attempts to imagine himself in the place of the patient, or an emotional process, where the subject participates actively in sharing the patient's emotions (Davis 1980; Kliszcz and Rembowski 1998). Studies on empathy in medicine often use the definitions interchangeably or fail to consider the impact of such conflation on methodological rigor and analysis validity (Pedersen 2009). The result has been an absence of clarity surrounding the processes and interpretations of emotional socialization in medicine. In summation, to date, no qualitative work has been done to explore how physicians identify with and understand these theories of emotion labor in the medical setting.

In this study, I will conduct qualitative interviews to study the process of emotional socialization in medicine. I will explore the meaning that physicians ascribe to empathy. After identifying definitions for the core aspects of emotion labor in clinical medicine, I will examine how physicians interpret the importance of empathy among their patient care duties, and how they understand the phenomenon of empathy change over time. From the sociological perspective, this study will identify the theoretical foundations that govern empathic behavior among physicians. From the medical perspective, these foundations of sociological theory will provide valuable insight towards educating on empathy, identifying potential causes of empathy

decline, and developing strategies for both preventing burnout and supporting those struggling with burnout. Thus, the narrative interview as a novel research method in this subject area offers value to both the sociological literature and the medical literature, and better enables the two lines of study to inform each other's work.

HYPOTHESIS

Past empirical studies on empathy in medicine have been constrained by the assumptions that researchers make about how physicians conceptualize, utilize, and maintain empathy in the clinical environment (Pedersen 2009). While there is a wide array of diversity in the study design, outcome measures, and subject population in existing publications, a common feature in a majority of the studies to date is that they make generalizations about patient-physician perceptions of empathy and clinical uses of empathy without consistently defining what empathy is. Consequently, studies often select measures that evaluate limited facets of emotion labor, empathy, or burnout, but then generalize from those narrow constructs to draw conclusions about these social phenomena as a whole. Such approaches bring into question the validity of the research design: are these surveys, indices, and behavioral codes actually reflective of how physicians define and incorporate emotional responsibilities into their daily labor?

This study, in contrast, is an attempt to better align the scholarly literature in medicine with that of sociology, bridging the quantitative findings of medical journals with the theoretical assertions of sociological research. I propose a study that will examine how physicians define empathy, how they manage emotional interactions within the broader scope of their clinical duties, and how they perceive changes to empathy as a personal and social process in the culture of medicine. The exploratory approach is essential to the research question. By situating physicians' perceptions of empathy in medicine within their own definitions of empathy and

emotion labor, this study can critically evaluate the meanings that past studies ascribed to these concepts and the validity of conclusions based on those prior concepts. As a framing device, I consider the idea of emotion in the clinical environment within the context of Hochschild's work on emotion labor and surface acting (Hochschild 1983). It is important to be cognizant of the bias introduced by projecting personal preconceptions onto perceptions-based research, and I am therefore reluctant to orient the study towards a preliminary hypothesis.

DATA AND METHODS

Consistent with the goal of conducting exploratory research, the study will involve a preliminary phase of participant observation, after which semi-structured interviews will be conducted to develop theory surrounding interpretation and relevance of emotion in the clinical setting.

The intended population of study is the set of attending physicians and residents specializing in emergency medicine (EM) at two level I trauma centers at urban academic hospitals in the southern United States. Emergency medicine is the specialty of interest because studies suggest that rates of burnout and emotional exhaustion, compared to other subspecialties of medicine, are among the highest in EM (Kuhn et al. 2009; Shanafelt et al. 2012). Given the limited sample size, a purposive sample design will be chosen, with criterion sampling to select physicians that are (a) members of the EM faculty or EM residency programs at the selected research sites, (b) currently engaged in some amount of clinical practice (e.g. are not completely committed to careers as research physicians). All attending physicians and residents at each trauma center (a total population size of 136) will be contacted via email and mail to solicit participation. Pending availability, demographic data on respondents will be compared with that of non-respondents to evaluate the potential for a methodological selection bias. Furthermore,

pending the availability of appropriate funding, prospective participants will be mailed an in-kind pre-incentive, such as a gift card, when solicited for enrollment in the study. Prior studies have demonstrated that use of financial incentives yields higher response rates and higher-quality data sets, so the pre-incentive is well suited for the study of such a limited population size (Bonke and Fallesen 2009; Sanchez-Fernandez et al. 2010).

In the first phase of research study, participant observation will be conducted to develop a familiarization with organizational structure, operational protocols, and professional standards in the emergency department. Entry will be obtained through contact with the supervising physicians at each clinical site, with subsequent completion of any documentation, patient privacy training, or research protocols review procedures as required per institutional guidelines. A critical limitation of the interview research strategy is that the data are perceptions of longitudinal experiences that are assessed retrospectively at specific time points. Therefore, a period of observation in the patient care setting will lend additional validity to the assumptions that are made when constructing the language of an interview guide, and it will also provide a natural context to the perceptions that subjects express during the interview. It is difficult to evaluate, based solely on physicians' descriptions of empathic behavior in the clinical setting, how those interview responses compare to their actual conduct. With participant observation, the researcher can use witnessed experiences as a baseline to ascertain the validity of perceptions in interview responses. Additionally, it makes little sense to ask physicians about how they manage empathy in their work or how the clinical environment affects their emotional labor unless the researcher has some direct experience with the work and environment that the physician is describing.

Participant observation will be conducted until it has been determined that sufficient exposure to organizational structure and norms has been obtained to permit formation of a reasonably valid interview guide. Essentially, participant observation will conclude when a saturation of observations is achieved in patient-physician communication, conversation among physicians about patients, environmental stressors of the emergency department setting, functional duties of physicians, and hierarchy relationships within the emergency medicine program, among other factors found to be relevant to the study. When additional instances of participant observation cease to yield a marginal benefit of additional insight in these areas of ethnographic study, interviews will begin. As needed, additional observation may be conducted at a later time for further substantiation of phenomena that interviews may uncover.

The second phase of study will conduct semi-structured interviews. The interview method draws insight on perceptions of meaning and allows for interpretive reflection of prior events. A limitation of the method selection is that interviews compromise the ability to naturally observe empathic behavior and emotion labor. Furthermore, they cast aspersions on the generalizability of the work to a broader scope, such as the perceptions of physicians in other cities and medical centers, or the perceptions of physicians in other subspecialties. In this area of emotion labor in clinical medicine, where most studies to date have used methods that make widely variable assumptions about how physicians define, employ, and develop empathic behavior, semi-structured interviews will lend additional insight on the aspects of 'meaning' and 'process' that prior studies have been unable to provide.

Subjects will be asked to describe their perceptions of the meaning of empathy. These definitions will then provide perspective for the discussion of their views on the prevalence and importance of empathy and emotion labor in effective clinical practice. The final segment of the

interview will ask subjects to describe their personal experiences and social observations of how empathy is developed, maintained, and/or eroded, both as part of the personal experience of physician-provider interaction and as part of the communal experience of emotional socialization in medicine. An interview guide will be constructed for this research phase, but research questions will be adapted over time if previously undetected aspects of emotion labor arise in conversation or if physicians discuss experiences that warrant investigation in further depth. Interviews will be conducted in person and, if necessary, by phone, then audiotaped and transcribed for further analysis. Interviews will conclude when thematic saturation—the point at which additional interviews cease to produce novel information on a phenomenon of interest—has been achieved. At present, given the population size of 136 attending physicians and residents, a baseline objective of 30 interviews (for a target response rate of ~25%) is projected. This objective may be revised at a later time, based on the response rate and the completeness of the interview responses towards constructing a valid and informative theory.

Analysis of the interview transcripts will be conducted within Creswell's interpretive framework of data analysis (Creswell 2009). All transcripts will be read by a researcher and codes will be developed that address the research questions of how emotional labor is defined, used, and developed/revised throughout clinical practice. The coder will develop codes after the transcripts are evaluated for commonly discussed views and phenomena, rather than relying on preconceived codes that potentially lend undue interpretations of the data. When text has been categorized by codes, comparisons of the data will be conducted to derive themes describing physician practice of emotion labor. These themes can then be evaluated within the broader perspective of sociological work on emotion labor and organizational sociology, with likely

implications for further work in sociological studies of clinical interactions and for medical literature on empathy and the social sciences of medicine.

ETHICAL CONSIDERATIONS, ACKNOWLEDGEMENTS, AND DISCLOSURES

Respondents will be provided with appropriate information, prior to participation, on the study's protocols, anticipated risks and benefits, the ability to withdraw, and the procedures for directing redresses, and written consent will be secured documenting this provision of information. Appropriate measures will be taken to ensure the digital security of interview recordings and transcripts. As required, the study will be submitted for the approval of the IRB at all institutions involved. Confidentiality of the respondents and their institutions will be maintained to the fullest appropriate degree, and any coded responses will be appropriately depersonalized prior to publication.

The researcher has significant prior exposure to the research setting and population in a clinical capacity as an emergency medical technician. While this alleviates some concerns over population access, it raises potential concerns regarding the existing presence of a personal rapport with prospective study respondents and the possibility that the role of the researcher as a detached observer may not be fully recognized or understood by the study population. During participant observation, adequate disclosure will be ensured so that physicians understand the objectives and degree of involvement of the researcher. Interviews will be conducted with the explicit disclosure that they are researcher-subject interactions, and any interview data obtained from interviews where a prior rapport exists will be scrutinized for consistency with interviews where no such prior rapport is in place. From a personal perspective, the researcher acknowledges a record of personal experience working with patients, both within and outside of the emergency department setting. Hence, there is a likelihood that participant observation and

interviewing may be influenced by the researcher's personal perceptions on empathy in patient-provider interactions. For these reasons, assurances of validity and methodological rigor, as discussed, have been incorporated into the research design.

APPENDIX: INTERVIEW GUIDE

Section 1: Clinical Background

1. To start off, could you walk me through your career path; that is, where you've studied and worked?
2. How long have you been a physician? Did you have any other career before you became a physician?
3. What motivated you to pursue a career in medicine?

Section 2: Conceptualization of Empathy

4. What do you think it means for a physician to display "empathy" towards a patient? (If this is difficult, prompt for situations that involve empathy or actions that constitute empathetic behavior.)
5. How do you think empathy fits within your scope of responsibilities as a physician? (Is it something central to clinical practice, or something optional, something detrimental, or something best delegated to another clinical professional, e.g. nurses?)
6. Do you think empathy is something that is outwardly shown, internally felt, or some combination of both? (Can someone be empathic without actively sharing their patients' emotional experiences?)

Section 3: Empathy in the Patient-Physician Relationship

7. Can you describe for me some examples or stories that show what role empathy or emotion plays in your everyday interactions with patients?
8. What effect does empathy have on your patients?

9. What effect does empathy have on you, as the physician? (What effect does it have on your ability to make clinical decisions? How does it influence your emotional well-being over time?)
10. How would you describe the attitude that other physicians have towards empathy, or how they practice empathy? How are their views and behaviors similar to yours, or different from yours?

Section 4: Empathy and Medical Socialization

11. What are the formal and informal ways that physicians receive training about empathy? (Coursework in medical school? Mentorship in clinical rotations? Experiences with patient contacts?)
12. As a medical student or resident, what kinds of advice were you given about how to manage your emotions when interacting when patients?
13. How do you think your interactions with patients have changed since you first started clinical rotations, and why do you think that is the case?
14. Have you ever encountered the perception in medicine that empathy compromises clinical effectiveness, or the perception that physicians should keep their emotions distinct from their work? How do you think such views are seen in the culture of medicine, and what is your opinion about the validity of such statements?
15. There are studies that show that physicians become less patient-centered and empathic as they spend more time in the clinical setting. How do you think your experiences compare with such findings? Do you think this is true of other physicians that you observe?
16. What influences do you think the environment of patient care has on empathy and physicians' emotional well-being?

17. What do you think the culture of medicine says about empathy and physicians' interactions with patients? Is emotional engagement something that is supported by the medical culture, or is it something that is cautioned against?
18. How do you think the current attitude towards empathy in clinical education and training compares with the attitude that was present during your time in medical school/residency? Do you think this change is a positive/negative one?

Section 5: Demographic Background

19. What is your current clinical rank or position title?
20. Approximately how many hours do you work per week?
21. How old are you?
22. Did you complete an undergraduate degree? If so, what was your major?
23. Do you identify with any religious background?
24. Do you identify with any race or ethnicity?
25. Are you married or in a long-term relationship? If so, what does your spouse or partner do?
26. Do you have children? If so, how many and how old are they?

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